Initial Approval: July 9, 2008
Revised Dates: April 13, 2016
January 8, 2014; April 11, 2012
November 12, 2008

**CRITERIA FOR PRIOR AUTHORIZATION**

Cimzia ® (certolizumab pegol)

**PROVIDER GROUP** Pharmacy Professional

**MANUAL GUIDELINES** The following drug requires prior authorization: Certolizumab Pegol (Cimzia)

**CRITERIA FOR CROHN'S DISEASE (CD):** (must meet all of the following)

- Patient must have a diagnosis of Crohn's disease
- Must be prescribed by a gastroenterologist
- Evaluation for latent tuberculosis (TB) with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has used a conventional Crohn's disease therapy (see attached table) **OR** there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional Crohn's disease therapy (see attached table)

**CRITERIA FOR RHEUMATOID ARTHRITIS (RA):** (must meet all of the following)

- Patient must have a diagnosis of rheumatoid arthritis
- Must be prescribed by a rheumatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

**CRITERIA FOR PSORIATIC ARTHRITIS (PSA):** (must meet all of the following)

- Patient must have a diagnosis of psoriatic arthritis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

**CRITERIA FOR ANKYLOSING SPONDYLITIS (AS):** (must meet all of the following)

- Patient must have a diagnosis of ankylosing spondylitis
- Must be prescribed by a rheumatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

**LENGTH OF APPROVAL** 12 months

| Biologic Agents | |
|---|---|
| **Generic Name** | **Brand Name** |
| Abatacept | Orencia® |
| Adalimumab | Humira® |
| Alefacept | Amevive® |
| Anakinra | Kineret® |
| Certolizumab | Cimzia® |
| Golimumab | Simponi® |
| Infliximab | Remicade® |
| Natalizumab | Tysabri® |
| Rituximab | Rituxan® |
| Tocilizumab | Actemra® |
| Tofacitinib | Xeljanz® |
| Ustekinumab | Stelara® |

| Conventional Crohn's Disease Therapies | |
|---|---|
| **Generic Name** | **Brand Name** |
| Azathioprine | Azasan®, Imuran® |
| Budesonide | Entocort® |
| Cortisone | Cortone® |
| Dexamethasone | Decadron®, Dexone®, Hexadrol®, Baycadron®, DexPak®, Zema-Pak® |
| Hydrocortisone | Hydrocortone®, Cortef® |
| Mercaptopurine | Purinethol® |
| Mesalamine | Apriso®, Lialda®, Cariasa®, Pentasa®, Asacol®, Rowasa®, SF-Rowasa®, Fiv-Asa® |
| Methotrexate | Trexall®, Rheumatrex® |
| Methylprednisone | Medrol®, MethylPred®, Meprolone UniPak® |
| Prednisolone | Prelone®, MilliPred®, OraPred®, VeriPred®, Bubbli-Pred®, PediaPred® |
| Prednisolone/Peak Flow Meter | AsmaPred Plus® |
| Prednisone | Orasone®, Meticorten®, SteraPred®, Deltasone®, Prenicen-M® |
| Sulfasalazine | Azulfidine®, Sulfazine® |